FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)	SOCIAL SECURITY NUMBER	DATE OF ACCIDENT (Month-Day-Year)	TIME OF ACCIDENT ☐ AM ☐ PM

HOME ADDRESS

Street/Apt#: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

( ) -

EMPLOYEE'S DESCRIPTION OF ACCIDENT (include Cause of Injury)

OCCUPATION	INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED

DATE OF BIRTH	SEX
	☐ M ☐ F

EMPLOYER INFORMATION

EMPLOYER/COMPANY

Monroe County Board Of County Commissioners
1100 Simonton Street, Suite 2-268
Key West, FL 33040

FEDERAL I.D. NUMBER (FEIN): 59-6000-749

NATURE OF BUSINESS: Municipality

DATE FIRST REPORTED (Month-Day-Year)

POLICY/MEMBER NUMBER: Self-Insured

TELEPHONE Area Code Number: (305) 292-4448

DATE EMPLOYED

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (if different)

Street:: _____

City: _____ State: _____ Zip: _____

Location # (if applicable):

LAST DAY EMPLOYEE WORKED

RETURNED TO WORK? ☐ YES ☐ NO
IF YES, GIVE DATE

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP?

PLACE OF ACCIDENT (Street, City, State, Zip)

Street:: _____

City: _____ State: _____ Zip: _____

County of Accident:

DATE OF DEATH (If applicable)

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY

$ PER ☐ HR ☐ WK ☐ DAY ☐ MO

Number of hours per day

Number of hours per week

Number of days per week

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign)

_____ DATE

_____ EMPLOYER SIGNATURE

_____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case – DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case – DWC-12, Notice Of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)
Employee's 8th Day Of Disability
Entity's Knowledge of 8th Day of Disability

☐ 3. Lost Time Case – 1st day of disability

Full Salary in lieu of comp? ☐ YES Full Salary End Date

Date First Payment Mailed AWW Comp Rate

☐ T.T. ☐ T.T.- 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $

Interest Amount Paid in 1st Payment $

REMARKS:

INSURER NAME: Monroe County BOCC

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
9345		

SERVICE CO/ TPA CODE #	CLAIMS-HANDLING ENTITY FILE #
6060	

CLAIMS-HANDLING ENTITY NAME, ADDRESSS & TELEPHONE

EMI
700 CENTRAL PARKWAY
STUART, FL 34994
TEL: (800) 431-2221
FAX: (772) 220-1637

Form DFS-F2-DWC-1 (08/2004)

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

Monroe County Florida

Accident/Incident Investigation Report **Send Immediately to Your Department Head**	Date Received Risk Mgt. __/__/__ Safety __/__/__

1. Name		2. Department	
3. Date	/ / / Time: AM PM	4. Location	
	M D Y	5. Job Title	

6. Location of Accident	
Street Address:	City/Key
7. Activity or task being done at time of accident	
8. Witness (include address and Phone	
1. Name:	Phone:
Street & #:	City:
2. Name:	Phone:
Street & #:	City:
9. **Describe Accident:**	

Was the injury:		Very Minor		Minor		Moderate		Serious	County Vehicle/Unit ID#

Employee

10. Employee's report on how & why accident occurred:
11. What do you recommend be done to prevent accident
Employee Signature: Date:

Supervisor

12. Supervisor report of how & why accident/incident occurred (**include unsafe act, cause & root cause**)			
			Continue on back ☞
13. What will be done to prevent reoccurrence? (remove, repair, barricade, retrain, etc.)			
Supervisor Signature:	**Print Name**:	Phone:	Date

Department Director

14. Dept. Dir. Comments & Recommendations:			
Dept. Dir. Signature: or: **Sheriff Office** Commander	**Print Name**:	Phone:	Date:

Division Director

15. Div. Dir. Comments & Recommendations:			
Div. Dir. Signature or: **Sheriff Office** Safety Rep.	**Print Name**	Phone:	Date:

Safety - Risk or Workers Comp

16. Safety, Risk or Workers Comp Administrator Recommendations:
Safety/Risk/Worker Comp Administrator:_____ Date Signature

MONROE COUNTY

For **RISK MANAGEMENT** only

REPORT OF INCIDENT

FAX IMMEDIATELY

RISK MANAGEMENT at 295-3179 (property damage or vehicle)
FAXED FROM:_____ **NUMBER:**_____

☐ **Employee injury** Notify workers comp ☐ **Vehicle Accident** Notify Risk Management ☐ **Other**

WHO:		Phone:
Name either employee or public		JOB TITLE if employee
SUPERVISOR:		
DEPARTMENT:		Vehicle ID #
WHAT: TYPE OF ACCIDENT		
WHERE: LOCATION OF ACCIDENT		
WHEN: DATE		AM/PM
MO/ DAY/ YR		TIME
WHY: DESCRIBE ACCIDENT		
DESCRIBE INJURY OR PROPERTY DAMAGE:		

MEDICAL ATTENTION REQUIRED: O O if yes report injury to Workers Comp also.
YES NO

If Personal Property Damage or Injury to the Public:
Name of Owner: _____
Address: _____
Phone #: _____

FILL OUT ACCIDENT INVESTIGATION REPORT AND NOTICE OF INJURY (if employee injury) AND SEND TO YOUR DEPARTMENT HEAD FOR COMMENTS AND SIGNATURES

CC: DEPARTMENT HEAD via FAX